UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

TANYA LOWELL,	)	
	)	
Plaintiff	)	
	)	
v.	)	***Civil No. 03-244-P-S***
	)	
DRUMMOND, WOODSUM & MACMAHON EMPLOYEE MEDICAL PLAN, et al.,	)	
	)	
Defendants/ Third-Party Plaintiffs,	)	
	)	
v.	)	
	)	
MACHIGONNE, INC.,	)	
	)	
Third-Party Defendant	)	

RECOMMENDED DECISION ON
CROSS-MOTIONS FOR SUMMARY JUDGMENT

Defendants Drummond, Woodsum & MacMahon Employee Medical Plan ("Plan") and Drummond Woodsum & MacMahon, P.A. ("DWM") (both, "Defendants") and plaintiff Tanya Lowell cross-move for summary judgment in this Employee Retirement Income Security Act ("ERISA") action challenging a denial of requested medical-plan benefits. *See generally* Defendants' Motion for Summary Judgment ("Defendants' S/J Motion") (Docket No. 21); Plaintiff's Motion for Summary Judgment, etc. ("Plaintiff's S/J Motion") (Docket No. 29); Complaint (Docket No. 1). For the reasons that follow, I recommend that the court grant Lowell's motion for summary judgment and deny that of the Defendants.

I. Summary Judgment Standards

Summary judgment is appropriate only if the record shows "that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). "In this regard, 'material' means that a contested fact has the potential to change the outcome of the suit under the governing law if the dispute over it is resolved favorably to the nonmovant. By like token, 'genuine' means that 'the evidence about the fact is such that a reasonable jury could resolve the point in favor of the nonmoving party.'" *Navarro v. Pfizer Corp*., 261 F.3d 90, 93-94 (1st Cir. 2001) (quoting *McCarthy v. Northwest Airlines, Inc.*, 56 F.3d 313, 315 (1st Cir. 1995)).

The party moving for summary judgment must demonstrate an absence of evidence to support the nonmoving party's case. *Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986). In determining whether this burden is met, the court must view the record in the light most favorable to the nonmoving party and give that party the benefit of all reasonable inferences in its favor. *Nicolo v. Philip Morris, Inc.*, 201 F.3d 29, 33 (1st Cir. 2000). Once the moving party has made a preliminary showing that no genuine issue of material fact exists, the nonmovant must "produce specific facts, in suitable evidentiary form, to establish the presence of a trialworthy issue." *Triangle Trading Co. v. Robroy Indus., Inc.*, 200 F.3d 1, 2 (1st Cir. 1999) (citation and internal punctuation omitted); Fed. R. Civ. P. 56(e). "As to any essential factual element of its claim on which the nonmovant would bear the burden of proof at trial, its failure to come forward with sufficient evidence to generate a trialworthy issue warrants summary judgment to the moving party." *In re Spigel*, 260 F.3d 27, 31 (1st Cir. 2001) (citation and internal punctuation omitted).

To the extent that parties cross-move for summary judgment, the court must draw all reasonable inferences against granting summary judgment to determine whether there are genuine issues of material fact to be tried. *Continental Grain Co. v. Puerto Rico Maritime Shipping Auth.*, 972 F.2d 426, 429 (1st

Cir. 1992). If there are any genuine issues of material fact, both motions must be denied as to the affected issue or issues of law; if not, one party is entitled to judgment as a matter of law. 10A Charles Alan Wright, Arthur R. Miller & Mary Kay Kane, *Federal Practice and Procedure* § 2720, at 336-37 (1998).

II. Factual Context

The parties' statements of material facts, credited to the extent either admitted or supported by record citations in accordance with Local Rule 56, reveal the following relevant to this recommended decision:[1]

Effective January 1, 2000, DWM established the Plan, an ERISA plan, for the benefit of its employees. Defendants' Statement of Undisputed Material Facts ("Defendants' SMF") (Docket No. 22) ¶ 2; Plaintiff's Statement of Material Facts ("Plaintiff's SMF") (Docket No. 30) ¶ 2. The Plan provides that DWM is the plan administrator and third-party defendant Machigonne, Inc. ("Machigonne") is the contract administrator. *Id*. ¶¶ 1, 3. Under the Plan, members submit their claims to Machigonne. *Id*. ¶ 4. The Plan permits Machigonne to examine claimants and to make determinations as to whether a particular treatment is medically necessary. *Id*. ¶ 5. A claimant who wishes to challenge a benefit determination presents an appeal to Machigonne. *Id*. ¶ 6. After a member appeals a determination, Machigonne must present the claimant with a final written decision stating the reason for its determination. *Id*. ¶ 7.

Under the heading "Covered Expenses" the plan document for the Plan ("Plan Document") provides in part:

> The following expenses are covered by this Plan, provided that they are incurred for care, services, and supplies and prescribed by a physician. . . .

[1] The parties efficiently submitted only one set of statements of material facts in connection with both motions.

> *The care that participants receive is based on decisions made by the participants and their physicians. A course of treatment may be appropriate for a particular illness or condition, but may not meet the definition of medically necessary. All services must be medically necessary to be eligible for payment under the Plan. If the participant elects to receive services, which are determined to be not medically necessary, the participant will be solely responsible for the payment of these services. Medical services received are only covered when prescribed and/or ordered by a licensed physician. To be medically necessary and appropriate, a service must be consistent with acceptable medical practice.*

Plaintiff's SMF ¶ 24; Defendants' Response to Plaintiff's Statement of Material Facts ("Defendants' Reply SMF") (Docket No. 32) ¶ 24. Under the heading "Covered Expenses" the Plan goes on to list as among "expenses . . . covered by [the] Plan," charges for inpatient hospital stays; charges for inpatient and outpatient hospital expenses for services and supplies incurred as a result of an illness or surgery; charges for pre-admission testing; charges for a professional anesthesiologist, radiologist or pathologist; charges of a surgeon; and charges for services of a physician for medical care and treatment." *Id*. ¶ 25. The Plan provides: "All services must be medically necessary to be eligible for payment under the Plan." Defendants' SMF ¶ 9; Plaintiff's SMF ¶ 9.

The Plan includes a list of "General Exclusions." *Id*. ¶ 10. The "General Exclusions" provide, in pertinent part: "Benefits will not be provided for any service that is not medically necessary and appropriate, including [those expenses identified in Exclusion 11], regardless of whether or not they are provided, performed or prescribed by a physician." *Id*. ¶ 11. Exclusion 11 excludes coverage for "[a]ny expense for weight reduction, nutritional or dietary counseling (except to the extent provided herein); smoking clinics, sensitivity training, encounter groups, educational programs (except as provided herein); career counseling, and activities whose primary purposes are recreational and/or social." *Id*. ¶ 12.

Lowell suffers from morbid obesity, a significant medical condition that increases the likelihood of developing diseases such as heart disease, diabetes, hypertension, pulmonary complications, certain

obesity-related cancers, degenerative joint disease and hepatobiliary disease and also typically results in shortened life expectancy and poor quality of life. Plaintiff's SMF ¶ 26; Defendants' Reply SMF ¶ 26. Gastric-bypass surgery is successful in resolving most medical conditions associated with severe obesity. *Id*. ¶ 27.

In October 2001 Lowell asserted a claim by requesting a pre-procedure determination from Machigonne that the Plan was obligated to pay the expenses of gastric-bypass surgery. Defendants' SMF ¶¶ 13-14; Plaintiffs' SMF ¶¶ 13-14. In connection with that first request for preauthorization, Machigonne obtained Lowell's medical records and sent them to Safeco Insurance Company ("Safeco") for review. Plaintiff's SMF ¶ 28; Defendants' Reply SMF ¶ 28. Machigonne selected Safeco for the review because Safeco insured the Plan against losses exceeding $30,000, and Machigonne's representative was sure that the costs associated with a gastric bypass procedure would exceed that amount. Plaintiff's SMF ¶ 29; Administrative Record ("Record"), filed by Machigonne, at 55.[2]

Also as part of her first request for preauthorization, Lowell saw a psychologist for a psychological evaluation to assist in the determination of her mental suitability for the surgery and consulted with a nutritionist for "weight loss management and pre-bariatric surgery counseling." Plaintiff's SMF ¶ 30; Defendants' Reply SMF ¶ 30. The Plan reimbursed Lowell's health-care providers for the expense of both the pre-surgical psychological testing and the nutritional/weight- loss consultation. *Id*. ¶ 31.

In December 2001 Machigonne informed Lowell that her request for preauthorization was denied on the ground that the surgery was not medically necessary. *Id*. ¶ 32. On March 6, 2003 a representative of the office of Dr. Michael Carroll inquired of Machigonne whether gastric bypass would be a covered

[2] The Defendants purport to qualify this statement, *see* Defendants' Reply SMF ¶ 29; however, the qualification is (*continued on next page*)

service. *Id*. ¶¶ 33, 37. In response to that inquiry Machigonne stated that pre-authorization of gastric-bypass surgery required analysis of "BMI [body mass index], history and physical, office notes for last 12 months, nutritional assessment, and psychological assessment." *Id*. ¶ 34. On March 6, 2003 the same representative of Dr. Carroll's office also spoke with a different Machigonne customer service representative. *Id*. ¶ 35. This representative told Dr. Carroll's office that if Machigonne received a request for predetermination of medical necessity, the information received with that request would be reviewed along with information received in connection with the prior request. *Id*.

On March 6, 2003 Lowell's psychological evaluation to determine her suitability for gastric-bypass surgery was updated. *Id*. ¶ 36. On March 11, 2003 Dr. Carroll saw Lowell for evaluation and treatment of morbid obesity, determined that she was an excellent candidate for laparoscopic gastric-bypass surgery and prescribed that surgery, as well as preoperative pulmonary evaluation, for her. *Id*. ¶ 37. Dr. Carroll's rationale for prescribing gastric bypass surgery is not to reduce weight for the sake of weight reduction; rather, it is to reduce or eliminate the associated morbidities, which he believed would occur in Lowell's case. *Id*. ¶ 38. The Plan reimbursed Lowell's health-care providers for the expense of both the updated psychological evaluation and the evaluation by Dr. Carroll. *Id*. ¶ 39.

On March 18, 2003 Machigonne denied Lowell's request for predetermination of benefits on the ground that gastric-bypass surgery is not covered under the Plan. *Id*. ¶ 40. That same day, Dr. Carroll's office appealed the denial. *Id*. ¶ 41. On March 24, 2003 a Machigonne account manager communicated to a colleague that "one major problem with [Lowell's claim] is that we originally denied as not medically necessary . . . ." *Id*. ¶ 42. On March 31, 2003 Medical Review Institute of America, Inc. completed its

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unsupported by any record citation and is on that basis disregarded, *see* Loc. R. 56(e).

review of Lowell's medical record and certain Plan documents. *Id*. ¶ 43. The reviewer concluded that "there is documentation that the procedure can be considered medically necessary in this particular case" but that the surgery should not be authorized on the basis that it was excluded from coverage under the Plan. *Id*.; Record at 177.[3] The reviewer was a surgeon specializing in laparoscopic procedures. Plaintiff's SMF ¶ 44; Defendants' Reply SMF ¶ 44.

On April 1, 2003 Machigonne informed DWM of the results of the review and noted that the "stop loss" insurer, Avemco Insurance Company ("Avemco"), "would only approve the gastric bypass if it is approved under the Plan. Since the plan would not cover, you would not have stop loss coverage is [sic] you decide to cover this procedure." *Id*. ¶ 45. As of April 4, 2003 the Plan had decided to "go with [Machigonne's] determination" of Lowell's claim and not to "go[] outside of the plan guidelines." Plaintiff's SMF ¶ 46; Record at 78.[4]

On April 11, 2003 Lowell appealed the denial of her request for preauthorization. Plaintiff's SMF ¶ 47; Defendants' Reply SMF ¶ 47. On May 8, 2003 representatives of Machigonne spoke with a representative of Avemco, who informed them that Avemco would "go with [Machigonne's] determination," *i.e*., because Machigonne had denied the claim Avemco more than likely would as well. Plaintiff's SMF ¶ 48; Record at 212.[5] On May 30, 2003 Catherine Liston of DWM conveyed the following information to Machigonne: "Matt [Arbo, of Healey Associates] has indicated that Avemco will not reinsure a claim for gastric bypass under the existing terms of our current policy with them, therefore, in

[3] My phraseology takes into account the Defendants' qualification. *See* Defendants' Reply SMF ¶ 43. Although the Defendants again fail to provide a record citation as required by Local Rule 56(e), it is clear that they are qualifying the same material cited by Lowell.

[4] The Defendants purport to qualify this statement, *see* Defendants' Reply SMF ¶ 46; however, their qualification is unsupported by any record citation and is on that basis disregarded, *see* Loc. R. 56(e).

[5] My phraseology takes into account the Defendants' qualification. *See* Defendants' Reply SMF ¶ 48. Although the (*continued on next page*)

the absence of this reinsurance protection over $35,000, the firm will let stand Machigonne's conclusion that the procedure is not covered under our plan as written." Plaintiff's SMF ¶ 49; Record at 220.[6] When she communicated this decision to Machigonne, Liston was under the impression that Lowell had made at least three prior claims for the same benefit and that Machigonne had "arrived at similar conclusions" with respect to those claims. Plaintiff's SMF ¶ 50; Defendants' Reply SMF ¶ 50.

On June 5, 2003 Machigonne account manager Darlene Bolduc advised Matthew Arbo of Healey Associates:

> I want to discuss concerns about addressing prior denials. We only have one prior denial here. I am not sure where you have prior denial information. I don't know how we would relate prior denials to this one appropriately. I think we should allow this predetermination to stand on its own. If the attorney and patient decide to sue Drummond we would have the prior denial to show the history.
>
> My other concern would be that I want to make sure the client understands that our legal staff feels they could very well lost [sic] in court based on the current wording in their plan document.

Id. ¶ 51. DWM ultimately decided not to include in the denial letter information concerning the denial of Lowell's previous request for preauthorization of gastric-bypass surgery. Plaintiff's SMF ¶ 52; Record at 230.[7] In a denial letter dated June 4, 2003 Machigonne wrote: "Expenses for weight reduction . . . are not covered under the medical plan. This is and always has been our standard interpretation of this clause in the

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Defendants again fail to provide a record citation as required by Local Rule 56(e), it is clear that they are qualifying the same material cited by Lowell.

[6] My phraseology takes into account the Defendants' qualification. *See* Defendants' Reply SMF ¶ 49. Although the Defendants again fail to provide a record citation as required by Local Rule 56(e), it is clear that they are qualifying the same material cited by Lowell.

[7] The Defendants purport to qualify this statement and to add a final additional fact, *see* Defendants' Reply SMF ¶¶ 52-53; however, neither the qualification nor the additional fact is supported by any record citation, and on that basis both are disregarded, *see* Loc. R. 56(e).

plan document. We must continue to uphold the denial of your request to [sic] predetermination of benefits." Defendants' SMF ¶ 19; Plaintiff's SMF ¶ 19.

On October 10, 2003 Lowell commenced this action alleging that the Plan should cover expenses arising out of her proposed gastric-bypass surgery. *Id*. ¶ 20. On November 24, 2003 the Defendants filed a third-party complaint against Machigonne seeking indemnification pursuant to an express provision in an Administrative Services Agreement. *Id*. ¶¶ 1, 21.[8] In a March 24, 2004 Memorandum of Decision and Order, this Court said: "[I]nasmuch as . . . [Lowell] has conceded that [the Defendants] possessed discretion to construe Plan terms, her complaint implicates the 'abuse of discretion,' rather than *de novo*, standard of review." *Id*. ¶ 22.

III. Analysis

Lowell challenges the Defendants' denial of benefits for gastric-bypass surgery pursuant to section 502(a) of ERISA, 29 U.S.C. § 1132(a), seeking in essence to compel them to afford Plan coverage of the procedure and related expenses. *See* Complaint ¶ 5 & p. 5.[9] This section provides, in relevant part, that "[a] civil action may be brought . . . by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]" 29 U.S.C. § 1132(a)(1)(B).

"The threshold issue in this case, like all ERISA cases, is to determine the appropriate standard of judicial review of the plan administrator's decision." *Crossman v. Media Gen., Inc*., 9 Fed. Appx. 147,

[8] The Defendants underscore that they have agreed to treat facts as "undisputed" for purposes of the instant motions only, *see, e.g*., Defendants' Reply SMF at 1 n.1, that their arguments "are without prejudice to [their] third-party action against Machigonne," and that "[i]n the event that the Court holds that the decisions denying the plaintiff's claim were incorrect, [they] reserve the right to press their third-party action and seek all available relief[,]" Defendants' S/J Motion at 7 n.3.

[9] Lowell also requests attorney fees and costs of suit, *see* Complaint at 5 – matters that are beyond the scope of this

(*continued on next page*)

149 (4th Cir. 2001). As it happens, I have already had occasion to answer that question, ruling by decision dated March 4, 2004 that the abuse-of-discretion, rather than *de novo*, standard of review applies in this case. *See* Memorandum Decision and Order on Defendants' Motions To Amend Scheduling Order (Docket No. 20) at 2-3. Lowell urges me to reconsider that ruling, *see* Plaintiff's S/J Motion at 2-5; however, as the Defendants note, *see* Defendants' Opposition to Plaintiff's Cross-Motion for Summary Judgment ("Defendants' S/J Reply") (Docket No. 31) at 2-3, the request comes too late.

With respect to magistrate judges' rulings on nondispositive matters, Federal Rule of Civil Procedure 72(a) provides, in relevant part: "Within 10 days after being served with a copy of the magistrate judge's order, a party may serve and file objections to the order; a party may not thereafter assign as error a defect in the magistrate judge's order to which objection was not timely made." Lowell did not object to, or otherwise "request reconsideration" of, my March 4, 2004 order until the filing of her cross-motion on May 14, 2004, *see* Docket, thereby effectively waiving any objection to that order, *see, e.g., Phinney v. Wentworth Douglas Hosp.*, 199 F.3d 1, 4 (1st Cir. 1999) (pursuant to Rule 72(a) "an objection to a magistrate judge's order must apprise the district court of all the objector's claims of error[.]").

As Lowell asserts, *see* Plaintiff's S/J Motion at 2-3, the court retains inherent power to revise an interlocutory order until such time as final judgment is entered, *see* Fed. R. Civ. P. 54(b). Assuming *arguendo* that a litigant who fails to lodge a timely objection to a magistrate judge's nondispositive ruling in accordance with Rule 72(a) may yet invoke Rule 54(b) in aid of a belated challenge, he or she would be obliged to demonstrate that reconsideration was in the "interests of justice." *See, e.g., Morgan v. Hatch*, 118 F.R.D. 6, 8 (D. Me. 1987) ("interests of justice" standard takes into consideration "(1) the

recommended decision and as to which I express no opinion. *See* Loc. R. 54.2 & 54.3.

egregiousness of [the movants'] counsel's conduct; (2) the prejudice caused to [the non-moving party] by the delay; (3) [the movants'] counsel's proferred excuse for the delay; and (4) the prejudice to the [movants] themselves, who were not personally responsible for the delay."). Lowell offers neither justification for her counsel's significant transgression of the Rule 72(a) ten-day deadline nor argument that she would be prejudiced by a failure to address the matter now. *See* Plaintiff's S/J Motion at 2-5. She accordingly falls short of making the type of showing that would warrant reconsideration under the rubric of the court's inherent power or of Rule 54(b).

Nonetheless, although Lowell loses this battle, she wins the war. I agree with her fallback position that even under the more deferential abuse-of-discretion standard, she is entitled to summary judgment as to her complaint. *See* Plaintiff's S/J Motion at 5-18. As the First Circuit recently has observed:

> When, as in this case, a plan administrator has discretion to determine an applicant's eligibility for and entitlement to benefits, the administrator's decision must be upheld unless it is arbitrary, capricious, or an abuse of discretion. In other words, the administrator's decision must be upheld if it is reasoned and supported by substantial evidence.

Gannon v. Metropolitan Life Ins. Co., 360 F.3d 211, 212-13 (1st Cir 2004) (footnote, citations and internal quotation marks omitted). The Defendants have presented no evidence disputing the medical necessity of Lowell's gastric-bypass surgery; instead, the parties clash over whether the Plan does or does not cover such an expenditure. *Compare* Defendants' S/J Motion at 3-6 *with* Plaintiff's S/J Motion at 5-18. The question presented thus is whether the Defendants' interpretation of the Plan to exclude such coverage is "reasonable."[10] *See, e.g.*, *Terry v. Bayer Corp.*, 145 F.3d 28, 40 (1st Cir. 1998) ("[I]n the ERISA context, it has been stated that under the arbitrary and capricious standard, a fiduciary's

[10] For simplicity's sake I ascribe the challenged interpretation to "the Defendants." In so doing I express no opinion as to whether Machigonne is or is not liable to the Defendants on their third-party claim.

interpretation of a plan will not be disturbed if reasonable.") (citation and internal quotation marks omitted); *Cheever v. John Hancock Mut. Life Ins. Co*., 206 F. Supp.2d 155, 162 (D. Mass. 2002) (Under arbitrary and capricious standard of review, "[t]he court will substitute its view only if the administrator's interpretation of the plan has crossed the boundary of what might plausibly be deemed reasonable"; court's task is accurately described as "requiring a determination whether the [Administrator's] interpretation rendered any language in the plan meaningless, whether the interpretation was consistent with the plan language, and whether the provision in question has been interpreted consistently.") (citations and internal quotation marks omitted).

Lowell suggests that the Defendants' construction is unreasonable inasmuch as it does not comport with the plain language of the Plan, read as an integrated whole, and has been inconsistent with respect to her own claims. *See* Plaintiff's S/J Motion at 8-18; *see also, e.g., Rodriguez-Abreu v. Chase Manhattan Bank, N.A.*, 986 F.2d 580, 586 (1st Cir. 1993) ("A contract is to be interpreted in a manner which gives reasonable effect to its terms and conditions. Contract language in an ERISA action is to be given its plain meaning.") (citations and internal punctuation omitted). I agree.

As an initial matter, the contemplated gastric-bypass surgery clearly meets the Plan's definition of a "Covered Expense." The Plan covers surgery and enumerated related expenses to the extent medically necessary. *See* Plaintiff's SMF ¶ 25; Defendants' Reply SMF ¶ 25 (Plan lists as among covered expenses "charges for inpatient hospital stays; charges for inpatient and outpatient hospital expenses for services and supplies incurred as a result of an illness or surgery; charges for pre-admission testing; charges for a professional anesthesiologist, radiologist or pathologist; charges of a surgeon; and charges for services of a

physician for medical care and treatment.").[11] And the cognizable facts reveal no genuine dispute that this surgery is medically necessary in Lowell's case. *See id*. ¶¶ 26-27.

The only remaining question is whether the Defendants nonetheless reasonably construed the Plan's Exclusion 11 to preclude coverage. I find that they did not. Exclusion 11 denies coverage for "[a]ny expense for weight reduction, nutritional or dietary counseling (except to the extent provided herein); smoking clinics, sensitivity training, encounter groups, educational programs (except as provided herein); career counseling, and activities whose primary purposes are recreational and/or social." Defendants' SMF ¶ 12; Plaintiff's SMF ¶ 12.

The Defendants construe the parenthetical phrase "except to the extent provided herein" to modify only the phrase "nutritional or dietary counseling." *See* Defendants' S/J Motion at 3-4. However, as Lowell asserts, from a grammatical point of view this is a strained reading of the text. *See* Plaintiff's S/J Motion at 12. As she points out, the Defendants' interpretation would make sense if Exclusion 11 were phrased to exclude coverage of expenses "for weight reduction, *or for* nutritional or dietary counseling" or, alternatively, "for weight reduction; for nutritional or dietary counseling." *See id*. However, given the presence of a comma between the phrases "weight reduction" and "nutritional or dietary counseling" and a semicolon after the parenthetical phrase "except to the extent provided herein," the parenthetical phrase most logically and naturally is read to modify all of the words preceding it.[12]

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[11] The Defendants attempt to make something of the fact that the Plan does not expressly provide coverage for surgical weight-reduction procedures or for gastric-bypass surgery. *See* Defendants' S/J Motion at 2-3. However, as Lowell rejoins, the Plan takes the general approach of covering "charges . . . incurred as a result of . . . surgery" and "charges of a surgeon" rather than listing specific covered surgical procedures such as appendectomies and heart surgery. *See* Plaintiff's S/J Motion at 8. Thus, a specific listing for gastric-bypass surgery would be superfluous.

[12] As Lowell further posits, *see* Plaintiff's S/J Motion at 12-13, the punctuation of Exclusion 11 suggests that the words "weight reduction," "nutritional" and "dietary" all modify the noun "counseling" – in other words, that coverage for the specified types of counseling (including weight-reduction counseling) is excluded except as otherwise provided. However, reasonable people could disagree as to this point.

Nonetheless, assuming *arguendo* that purely as a grammatical matter the Defendants' preferred reading is reasonable, albeit strained, there is a further snag: It does not comport with the overall sense and meaning of the Plan. The prefatory language to the General Exclusions (including Exclusion 11) indicates that their aim is to preclude coverage for medically unnecessary and inappropriate treatment, regardless whether performed or prescribed by a physician. *See* Defendants' SMF ¶ 11; Plaintiff's SMF ¶ 11.[13] Consistent with that intendment, Exclusion 11 contains a laundry list of services that typically would be classified as lifestyle enhancements rather than medical necessities (or, in the catchall language of Exclusion 11, "activities whose primary purposes are recreational and/or social"), *e.g.*, smoking clinics, dietary counseling, sensitivity training, encounter groups and educational programs. Yet Exclusion 11 recognizes, by way of its carveouts, that in certain instances coverage is otherwise provided (*i.e.*, certain of these types of services in some instances would be medically necessary and appropriate). Thus, Exclusion 11 reasonably would be construed to bar coverage of a Weight Watchers membership intended to help the beneficiary lose twenty pounds but not reasonably construed to bar coverage of medically necessary and appropriate gastric-bypass surgery.

In short, to employ a strained interpretation of the plain language of Exclusion 11 to arrive at an outcome that does not comport with its stated purpose simply is not a "reasonable" exercise of plan-

[13] The Defendants argue that the prefatory language to the General Exclusions cannot be construed to profess an intention to cover all medically necessary services inasmuch as certain of the specific exclusions actually bar coverage of services that may be medically necessary (*e.g.*, exclusions for coverage of treatment of injuries incurred at the workplace or in war). *See* Defendants' S/J Motion at 5. In the Defendants' view, Lowell's reading would nullify such exclusions. *See id*. I disagree. The prefatory language unambiguously and emphatically expresses the Plan's intention to exclude coverage of services that are not medically necessary and appropriate, even if ordered or performed by a physician. The fact that certain specific exclusions bar coverage even for medically necessary services is not inconsistent with that overall design. It is entirely appropriate to look to the clearly stated purpose of the General Exclusions in construing Exclusion 11.

interpretation discretion.[14] *See, e.g., Smart v. Gillette Co. Long-Term Disability Plan*, 70 F.3d 173, 179 (1st Cir. 1995) (noting, in ERISA plan-interpretation case, "Accepted canons of construction forbid the balkanization of contracts for interpretive purposes. . . . Where the whole can be read to give significance to each part, that reading is preferred.") (citations and internal punctuation omitted).

The Defendants' woes do not end there. As Lowell further notes, *see* Plaintiff's S/J Motion at 13-15, even assuming *arguendo* that Exclusion 11 reasonably can be construed to preclude coverage of any expenditures "for weight reduction" (without the qualifying language "except to the extent provided herein"), a further question arises: Are her expenses "for weight reduction"? On this point, the only evidence of record is that Lowell's physician, Dr. Carroll, prescribes gastric-bypass surgeries not to reduce weight for the sake of weight reduction but rather to reduce or eliminate associated morbidities, which he believed would occur in Lowell's case. *See* Plaintiff's SMF ¶ 38; Defendants' Reply SMF ¶ 38. Thus, the determination that Lowell's gastric-bypass expenditures were "for weight reduction" is unsupported by any (let alone "substantial") evidence of record.

One final point remains. As Lowell contends, *see* Plaintiff's S/J Motion at 7, 17-18, a plan administrator's inconsistent interpretation of disputed language is a hallmark of arbitrariness, *see, e.g., Chevron Chem. Co. v. Oil, Chem. & Atomic Workers Local Union 4-447*, 47 F.3d 139, 145 (5th Cir. 1995) (noting that analysis of whether a plan administrator's interpretation of a plan is legally correct entails, *inter alia*, consideration of "whether the administrator has given the plan a uniform construction" that is "consistent with a fair reading of the plan"); *Doyle v. Nationwide Ins. Cos. & Affiliates Employee Health*

[14] As Lowell argues, had the Plan intended to exclude medically necessary surgery that involved weight reduction, it could have used clear language to achieve that result. *See* Plaintiff's S/J Motion at 12-13; *Templet v. Blue Cross/Blue Shield of La.*, No. Civ.A. 99-1400, 2000 WL 1568219, at *1 (E.D. La. 2000) (plan excluded coverage of "any Surgery for morbid obesity . . . regardless of Medical necessity").

Care Plan, 240 F. Supp.2d 328, 345-46 (E.D. Pa. 2003) (setting forth five-factor test of reasonableness of a plan administrator's interpretation of plan language that includes "whether the interpretation is consistent with the goals of the Plan" and "whether the [relevant entities have] interpreted the provision at issue consistently") (citations and internal quotation marks omitted).[15]

The record in this case betrays behind-the-scenes confusion as to whether Lowell's proposed surgery was or was not excluded from coverage under the Plan. Her initial request in 2001 was denied not on the basis of exclusion but on the basis of lack of medical necessity. When a representative of Dr. Carroll's office pointedly inquired in 2003 whether gastric-bypass surgery was a covered service, he was lead to believe that it was (provided the hurdle of medical necessity could be overcome). Indeed, tellingly, the Plan reimbursed certain of Lowell's expenditures in both 2001 and 2003 in connection with the requested surgery – expenses that logically it should not have paid had it considered the procedure either not to have been a covered service or to have been foreclosed from coverage by operation of Exclusion 11.

For this and all of the foregoing reasons, I find that even under the deferential "arbitrary and capricious" standard of review, the Defendants' handling of the instant claim falls short. Their interpretation of the Plan language in question to deny coverage for Lowell's medically necessary gastric-bypass surgery was not a reasonable exercise of discretion.

IV. Conclusion

For the foregoing reasons, I recommend that the court **GRANT** Lowell's motion for summary judgment and **DENY** that of the Defendants.

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[15] The Defendants cite *Liston v. Unum Corp. Officer Severance Plan*, 330 F.3d 19, 25 (1st Cir. 2003), for the proposition that inasmuch as Lowell did not raise the issue of Machigonne's payment/handling of her other claims during the claim and appeal process, she has waived the right to do so now. *See* Defendants' S/J Reply at 3. However, I read the cited passage of *Liston* to bear on the question of whether a claimant has waived the right to discover third-party claim files. (*continued on next page*)

NOTICE

A party may file objections to those specified portions of a magistrate judge's report or proposed findings or recommended decisions entered pursuant to 28 U.S.C. § 636(b)(1)(B) for which de novo review by the district court is sought, together with a supporting memorandum, within ten (10) days after being served with a copy thereof. A responsive memorandum shall be filed within ten (10) days after the filing of the objection.

Failure to file a timely objection shall constitute a waiver of the right to de novo review by the district court and to appeal the district court's order.

Dated this 13th day of July, 2004.

/s/ David M. Cohen
David M. Cohen
United States Magistrate Judge

Plaintiff

TANYA LOWELL represented by **CHRISTOPHER C. TAINTOR**
NORMAN, HANSON & DETROY
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LEAD ATTORNEY
ATTORNEY TO BE NOTICED

V.

Defendant

DRUMMOND WOODSUM AND represented by **JENNIFER MARKOWSKI**

See Liston, 330 F.3d at 25.

MACMAHON EMPLOYEE MEDICAL PLAN		PEABODY & ARNOLD 50 ROWES WHARF BOSTON, MA 02110 617-291-2100 *ATTORNEY TO BE NOTICED* **JOHN J. O'CONNOR** PEABODY & ARNOLD 50 ROWES WHARF BOSTON, MA 02110 617-951-2100 Email: joconnor@peabodyarnold.com *ATTORNEY TO BE NOTICED*
DRUMMOND WOODSUM AND MACMAHON P A	represented by	**JENNIFER MARKOWSKI** (See above for address) *ATTORNEY TO BE NOTICED* **JOHN J. O'CONNOR** (See above for address) *ATTORNEY TO BE NOTICED*

ThirdParty Plaintiff

DRUMMOND WOODSUM AND MACMAHON EMPLOYEE MEDICAL PLAN	represented by	**JENNIFER MARKOWSKI** (See above for address) *ATTORNEY TO BE NOTICED* **JOHN J. O'CONNOR** (See above for address) *ATTORNEY TO BE NOTICED*
DRUMMOND WOODSUM AND MACMAHON P A	represented by	**JENNIFER MARKOWSKI** (See above for address) *ATTORNEY TO BE NOTICED* **JOHN J. O'CONNOR**

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ATTORNEY TO BE NOTICED

V.

ThirdParty Defendant

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